Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.caldocinfo.ca.gov

APPLICATION TO RESTORE LICENSE FROM DISABLED STATUS TO ACTIVE STATUS WITH LIMITATIONS ON PRACTICE ***Please print or type.*** ***Illegible applications will be returned.***	FOR OFFICE USE ONLY Fee Paid: _____ Receipt No.: _____ Date Cashiered: _____ Cashier's Intl: _____ Date Approved: _____ Date Denied: _____ Enforcement Approval: _____Yes _____No Date: _____
Name (first, middle, last):	
Address: Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse.	
Telephone Number: **FAX Number (if applicable):**	Telephone ( ) FAX ( )
Social Security Number:	
California Medical License Number:	

Part 1. DISABLED STATUS. ***Please provide all information requested below.***

Have you been granted a continuing medical education (CME) waiver by the Board?		No		Yes	If yes, enter year.

NOTE TO ATTENDING PHYSICIAN: The applicant previously submitted an application for "Disabled" status to the Medical Board of California, which was approved. The applicant documented the inability to practice medicine due to a disability or illness. The applicant is now requesting to be removed from "Disabled" status and agrees to limit his or her practice in a manner prescribed by the reviewing physician. Under State law, the applicant must establish to the satisfaction of the Board that the illness or disability no longer exists or does not affect the applicant's ability to practice medicine safely. As the applicant's attending physician, please provide the information requested below.

The Following Must Be Completed By Your Attending Physician:

Approximate date illness began: _____ Duration of illness: Temporary _____ Permanent_____

If "temporary", approximate date the applicant will be able to return to practicing medicine:_____

Does the applicant's current state of health prevent the applicant from practicing medicine safely? Yes ___ No ___
If yes, please explain in the space below. If additional space is needed, please include an attachment.

Applicant restrictions or limitations. Please describe specific practice limitations (e.g., no surgery).

Attending Physician's Name | Telephone Number

Attending Physician's Address | City | State | Zip

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including supporting documents, is true and correct and that I am licensed to practice medicine in the United States of America.

Attending Physician's Signature | Date

Attending Physician's License Number | State Attending Physician is Licensed

I certify under penalty of perjury under the laws of the State of California that the information contained in this application, including supporting documents, is true and correct and that I am licensed to practice in the State of California and I agree to limit my practice in the manner described above by the attending physician.

Applicant's Signature | Date

CURRENT MAILING ADDRESS

☐ **Check here if this is a change of address** so that your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address.

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals. Agency Name: Medical Board of California, Licensing Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825; Telephone: (916) 263-2344. The official responsible for information maintenance is the Chief. The authority, which authorizes the maintenance of the information, is the Business and Professions Code Public Law 94-455(42 U.S.C.A. 405(c)(2)(C)) authorizes collection of your social security number (SSN) and/or federal employer identification number (FEIN). Your SSN and/or FEIN will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. If you fail to disclose your SSN or FEIN, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you. Failure to provide all or any part of the requested information will result in this form being rejected as incomplete. The principal purpose(s) for which the information is to be used is to determine your eligibility to restore your license to active status pursuant to Sections 704, 2439, 2440, 2441 and 2442 of the Business and Professions Code. Any known or foreseeable interagency or intergovernmental transfer which may be made of the information, when necessary, is to other federal, state and local law enforcement agencies. Each individual has the right to review the files or records maintained on them by the agency, except for information which is exempt from disclosure.